



## CENTRON SECURITY SERVICES

## Daily Security Report

Client No. <b>2036</b>		Client Name <b>CH METELS</b>				Location <b>10020 SWEET ST. UTICA, NY</b>		Date <b>12/19/86</b>																			
Facility Equipment	Detox Clock	Weapon No.	Holster	Nightstick	Raincoat	Flashlight	Other <b>GATE &amp; TRAILER KEYS</b>																				
Officers: Fully explain all items marked "Yes" with time and all detail. For additional space use reverse side and attach incident reports.			Officer—Day Shift (Name) <b>Kenneth Felix</b>			Officer—Swing Shift (Name) <b>ofc DelVecchio</b>			Officer—Grave Shift (Name) <b>COATES, EUGENE</b>																		
Shift			Shift			Shift			Shift																		
Began <b>8 AM</b> Ended <b>4 AM</b>			Began <b>4 AM</b> Ended <b>12 PM</b>			Began <b>12 PM</b> Ended <b>8 AM</b>			Began <b>8 AM</b> Ended <b>4 PM</b>																		
Observations or actions taken	Yes	No	Explanation			Yes	No	Explanation			Yes	No	Explanation														
Rounds or stations missed		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>															
Unlocked doors, gates or windows		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>															
Unlocked vaults or safes		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>															
Fire-smoke-or hazards		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>															
1. Extinguishers missing or defective		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>															
2. Sprinkler system defective		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>															
3. Fire doors or exits blocked		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>															
4. Rubbish accumulation		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>															
5. Motors running		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>															
6. Lights left burning		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>															
Injury hazards		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>															
Visitors		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>															
Trespassing		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>															
Violation of company rules		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>															
Remarks <b>VISUAL CKT.-BLDN. PERIMETER INCLUDING FENCE LINE (P.C.)</b>																											
<b>Checked premise, bldg, fence line every hr. (X-7)</b>																											
<b>made visual check every hour, large hole in fence on drug side (P.C.)</b>																											
<b>IMPORTANT:</b> If you were ill or injured please explain on the reverse side of this form and call your supervisor before leaving this post.																											
1. Were you injured during this tour?		Day Shift		1.		2.		3.		Swing Shift		1.		2.		3.		Grave Shift		1.		2.		3.			
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Yes		No		Yes		No		Yes		No		Yes		No		Yes		No		Yes		No			
2. Did you suffer any illness?		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Yes		No		Yes		No		Yes		No		Yes		No		Yes		No		Yes		No	
3. Have you reported all accidents coming to your attention?		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Yes		No		Yes		No		Yes		No		Yes		No		Yes		No		Yes		No	
Signatures		1		2		3		1		2		3		1		2		3		1		2		3			
		<b>Kenneth Felix</b>						<b>ofc DelVecchio</b>						<b>Eugene K Coates</b>													
Signatures		2		2		2		2		2		2		2		2		2		2		2		2			
Signatures		3		3		3		3		3		3		3		3		3		3		3		3			

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